THE RECOVERY KERNEL

Substance-Specific Navigation Series

HOW TO RECOVER FROM PSILOCYBIN

Using the Recovery Kernel Framework

Magic Mushrooms · Shrooms · Psilocybe cubensis · Caps · Chocolate · Truffles · Microdosing · Plant Medicine

⚠ HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE | Crisis: call 911 or text 988

PSILOCYBIN DOES NOT PRODUCE PHYSICAL DEPENDENCE OR WITHDRAWAL. THE CHALLENGES ARE PSYCHOLOGICAL.

The compendium names it precisely: Shrooms, Magic Mushrooms → Psilocybin. Active compound, not the packaging.

A Note Before You Begin

The Recovery Kernel Compendium's precision vocabulary table names psilocybin with its own particular framing: 'Shrooms, Magic Mushrooms → Psilocybin. Active compound, not the packaging.' The distinction matters. The packaging — the mushroom body, the chocolates, the teas, the truffles — is delivery mechanism. The active compound is psilocybin, which is dephosphorylated to psilocin in the body and gut, and psilocin is what activates the brain.

The LSD guide in this series covers the adjacent territory extensively — the 5-HT2A mechanism, default mode network suppression, ego dissolution, HPPD, integration failure, psychosis risk, and the natural porting architecture. Much of that guide applies here, because psilocybin and LSD are both classical serotonergic psychedelics acting on the same primary receptor. Read the LSD guide alongside this one.

What this guide addresses is what is distinct about psilocybin specifically. The differences are significant enough to warrant a separate guide: psilocybin is metabolized entirely differently from LSD (phosphatase enzymes, not CYP450 — no CYP2D6 involvement), produces a shorter and often more emotionally intense experience, has a richer and more specific cultural and indigenous tradition than LSD, is advancing through clinical trials for depression and other conditions at a pace that has outrun LSD, and has a distinct use pattern that includes the

microdosing phenomenon — a sub-perceptual dose practice that has no direct LSD parallel in clinical discussion.

The compendium's LSD framework describes the universe opening through prefrontal inhibition. For psilocybin, the same mechanism produces the same opening — but the character of what enters is often more emotionally textured, more relational, and more specifically oriented to the person's own psychological content. The research finding that most consistently predicts psilocybin's therapeutic outcomes is the mystical experience score — a specific phenomenological state of oceanic boundlessness, sacredness, noetic quality, and positive affect that the research community has operationalized through validated scales. This dimension is unique to psilocybin in clinical research and is addressed directly in this guide.

Section 0 — Immediate Safety

⚠ THE ACUTE DANGERS OF PSILOCYBIN ARE PSYCHOLOGICAL, NOT PHYSIOLOGICAL. PSILOCYBIN ALONE DOES NOT PRODUCE RESPIRATORY DEPRESSION, CARDIAC EVENTS, OR OVERDOSE DEATH AT ANY DOSE DOCUMENTED IN THE LITERATURE. THE EMERGENCY IS BEHAVIORAL — DANGEROUS ACTIONS TAKEN DURING A DIFFICULT EXPERIENCE.

0.1 — The Difficult Experience Protocol

A difficult psilocybin experience is not a medical emergency in most cases. The principles from the LSD guide apply entirely:

- Change environment: move to a quiet, dim, familiar, safe space. Reduce all sensory input.
- Have a sober support person present: a calm, trusted sitter is the most effective intervention for a difficult psilocybin experience. Their calm is pharmacologically relevant — emotional states are perceived acutely during psilocybin.
- Do not resist the experience: the Jungian principle of psilocybin therapy applies — 'surrender, don't fight it.' Resistance intensifies difficult material. Acceptance — even of difficult content — allows the experience to move.
- Benzodiazepines if needed: diazepam 10mg or lorazepam 1–2mg significantly reduces the anxiety component without fully terminating the psilocybin state. This is the pharmacological management option for severe anxiety during a session.
- Call 911 only if: the person is a genuine danger to themselves or others, is experiencing a psychiatric break with lost reality testing, or has a medical emergency.

0.2 — What Psilocybin Is NOT

Psilocybin is frequently confused with other substances in the cultural conversation about psychedelics. Clarity prevents harm:

- Psilocybin does not cause respiratory depression (not an opioid receptor agonist)
- Psilocybin alone does not produce the cardiac emergencies associated with stimulants
- Psilocybin does not interact fatally with SSRIs through serotonin syndrome at standard doses — SSRIs primarily reduce psilocybin's effects by downregulating 5-HT2A receptors, not by producing dangerous serotonin

excess (SSRIs are reuptake inhibitors, not releasers; the interaction with psilocybin is dampening rather than additive)

- Psilocybin does not cause physical withdrawal — stopping is not a medical event

0.3 — What Psilocybin CAN Cause That Requires Medical Attention

- Psychosis precipitation in susceptible individuals (personal or family history of schizophrenia, schizoaffective disorder, bipolar disorder with psychotic features) — the same absolute contraindication as LSD
- HPPD (Hallucinogen Persisting Perception Disorder) — managed as per the LSD guide Section 4
- Serotonin syndrome (rare but documented with MAOIs, certain antidepressants, or tramadol — psilocybin's 5-HT2A agonism combined with MAOI serotonin accumulation)
- Nausea and vomiting (common and not medically dangerous in most cases — but aspiration risk if vomiting while sedated; recovery position)
- Species misidentification toxicity: poisonous mushroom species misidentified as psilocybe mushrooms. Amanita phalloides ('death cap') misidentification is potentially fatal. If mushroom toxicity is suspected (not psilocybin effect but severe GI distress, liver symptoms): emergency evaluation.

0.4 — Harm Reduction for Active Use

- Species verification: Psilocybe cubensis is the most commonly cultivated and the safest to identify. Wild-foraged mushrooms carry species misidentification risk. Use cultivated mushrooms from known sources where possible.
- Reagent testing: Ehrlich reagent turns purple in the presence of indole alkaloids including psilocybin. Tests that do not turn purple suggest psilocybin is not present.
- Set and setting: the compendium names set and setting as the primary determinants of psychedelic experience quality. Mental state, intentions, and physical environment shape the experience profoundly. High-risk contexts: alone, in an unfamiliar or unsafe environment, in a mental health crisis, with substances that interact.
- Psychosis contraindication: personal or family history of schizophrenia, schizoaffective disorder, or bipolar with psychosis. This contraindication is absolute regardless of dose.

Section 1 — What Psilocybin Did to Your Brain

THE CENTURION — The Same Receptor as LSD — Different Kinetics, Different Character, Different Cultural Roots

Psilocybin is a naturally occurring tryptamine found in over 200 species of fungi. The active compound — psilocin (produced when psilocybin loses its phosphate group) — is a partial agonist at 5-HT2A serotonin receptors with high affinity. This is pharmacologically identical to LSD's primary mechanism.

What is different: the kinetics, the metabolism, the duration, the phenomenological character, and the historical and cultural context. Understanding each explains why psilocybin is not simply 'shorter LSD.'

1.1 — Psilocybin vs. LSD: The Clinical Differences

Variable	Psilocybin	LSD (for comparison)
Primary active compound	Psilocin (after dephosphorylation of psilocybin)	LSD (lysergic acid diethylamide)
Metabolism	Phosphatase enzymes in the gut and liver rapidly convert psilocybin → psilocin. NO CYP450 involvement. Drug-drug interactions through CYP2D6 or CYP3A4 are not significant for psilocybin itself.	CYP3A4 (primary) and CYP2D6 (secondary) hepatic clearance. Multiple drug interactions through these pathways.
Duration	4–6 hours. Peak at 1–2 hours after ingestion. Resolution typically by hour 6. Significantly shorter than LSD for the same depth of experience.	8–12 hours. Much longer active window. The extended duration contributes to both the depth and the challenge of LSD experiences.
5-HT2A receptor kinetics	Psilocin dissociates from the 5-HT2A receptor relatively quickly — contributing to the shorter duration.	LSD has exceptionally slow 5-HT2A receptor dissociation — the receptor remains occupied long after plasma LSD levels decline, explaining LSD's long duration and slow offset.
Phenomenological character	More emotionally intense than LSD at equivalent depths; more often described as relational (about people, connections, relationships); more likely to surface personal psychological	Somewhat more perceptual/visual than psilocybin at comparable doses; the 'vast significance' quality of the LSD experience is described more often in cosmic or abstract

	content; more introspective. The Mazatec curandera María Sabina described the mushroom as a 'language' — psilocybin tends to speak in emotional and relational terms.	terms; can be more stimulating and less sedating than psilocybin.
Nausea	Common, particularly in the first 30–90 minutes from oral mushroom ingestion. The beta-glucan chitin in the mushroom body contributes to nausea beyond the psilocybin effect itself. Ginger, fasting before use, and lemon-tek preparation (psilocin converted before ingestion) all reduce nausea.	Less common than with mushroom ingestion. Liquid LSD and blotter paper do not carry the gastrointestinal content of the mushroom body.
Therapeutic evidence base	More extensive than LSD as of 2026. Psilocybin has FDA Breakthrough Therapy designation for both major depressive disorder (MDD) and treatment-resistant depression (TRD). Phase 3 trials in MDD, TRD, OCD, alcohol use disorder, and anorexia nervosa. Approved in Oregon (Measure 109) and Colorado for supervised therapeutic use.	Less advanced clinical trial program. FDA Breakthrough Therapy designation not yet achieved as of 2026. Active trials for alcoholism and anxiety but smaller evidence base.

1.2 — The Mystical Experience: What Predicts Psilocybin's Therapeutic Outcomes

THE CENTURION — The Compendium Names It: Touching God → Experiencing Serotonin and Dopamine Flood Beyond Natural Parameters

The compendium's precision vocabulary table includes the psychedelic experience framing: 'Touching God → Experiencing serotonin and dopamine flood beyond natural parameters.' For psilocybin specifically, the research has operationalized this experience with unusual precision.

Studies at Johns Hopkins, NYU, and Imperial College London consistently find that the predictor of psilocybin's therapeutic outcome is the intensity of the mystical-type experience produced during the session — measured by validated scales (the Mystical Experience Questionnaire, the Revised Mystical Experience Questionnaire) that assess:

- Oceanic boundlessness: the dissolution of the boundary between self and world; the sense of unity with all of existence
- Noetic quality: the experience conveys genuine knowledge — a felt sense of having learned something real about the nature of things

- Sacredness: the quality of the experience as holy, numinous, or transcendent
- Deeply felt positive mood: not merely pleasant but deeply meaningful and joyful
- Transcendence of time and space: the ordinary coordinates of experience temporarily suspend
- Ineffability: the experience is beyond adequate verbal description

These dimensions — collectively the 'mystical experience' — predict depression remission, addiction cessation, anxiety reduction, and increases in psychological well-being at 3-month follow-up with higher reliability than any other variable including dose. This is the empirical basis for the psychedelic therapy hypothesis: the mystical experience produces therapeutic change.

The recovery framework must hold this finding alongside the recovery challenge. The person who had profound, life-changing psilocybin experiences — and who developed a problematic relationship with them — encountered something real. The compendium's framing is exactly right: the serotonin flood was beyond natural parameters. The significance was the brain interpreting its own altered state. Both are true. The work of recovery is building direct access to the states those experiences pointed toward.

1.3 — The Dose Architecture

Dose category	Approximate dose	Primary experience	Recovery-relevant notes
Microdose	0.05–0.3g dried mushroom (approx 1–5mg psilocybin)	Sub-perceptual: no visual phenomena or altered state. Subtle mood enhancement, increased creativity, reduced rumination, possible anxiety reduction. Effects mostly felt the following day ('afterglow').	Distinct use pattern with distinct recovery considerations. See Section 4.4 (microdosing). Not associated with HPPD or psychosis at these doses. Can develop its own compulsive pattern.
Low / moderate	1–2g dried mushroom (approx 4–10mg psilocybin)	Mild to moderate psychedelic effects: visual enhancement, mood elevation, music intensification, mild ego softening. The 'social dose' range. Effects felt but reality grounding maintained.	The most common recreational dose range. Less likely to produce the full mystical experience but more manageable. HPPD risk lower at this range. Integration work still relevant.
High / therapeutic	3–5g dried mushroom (approx	Strong to full psychedelic experience: significant	The dose range most likely to produce both

	20–35mg psilocybin)	ego dissolution, visual phenomena, DMN suppression, possible mystical experience. This is the therapeutic dose range — used in clinical trials at 25mg psilocybin.	the therapeutic mystical experience AND the challenging difficult experience. Integration work is most critical here. HPPD risk increases. Psychosis risk most relevant. Requires appropriate setting and support.
Heroic / very high	5g+ (Terence McKenna's 'heroic dose' term)	Complete ego dissolution; profound perceptual alterations; potential for both the most profound and most terrifying experiences available through psilocybin. Rarely used in therapeutic context — clinical research uses 25mg purified psilocybin.	The doses most associated with integration backlog, HPPD risk, and the psychological difficulties described in this guide. Not suitable for unsupported use.

1.4 — Why Psilocybin Use Becomes Problematic

Psilocybin does not produce physical dependence or withdrawal. It has essentially no dopaminergic reward mechanism (not a conventional addiction liability). Rapid tolerance (tachyphylaxis) prevents daily use from being pharmacologically rewarding. By every conventional addiction metric, psilocybin scores extremely low.

The problems that develop are:

Problem	What it is	Recovery response
Integration failure and backlog	Experiences arriving faster than they can be metabolized into meaning. The same accumulation documented in the LSD guide — the psychological material from multiple intense experiences without adequate processing time creating instability, anxiety, and confusion.	The integration toolkit from Section 5 of the LSD guide applies directly. Journaling during the afterglow window. Psychedelic-informed therapy. Contemplative community. The resolution of the backlog is the primary psychological recovery target.
HPPD	Hallucinogen Persisting Perception Disorder — visual phenomena persisting beyond the session. Generally less common with psilocybin than LSD but documented with heavy use.	Complete psilocybin and cannabis cessation. The HPPD management protocol from the LSD guide Section 4 applies. Most cases resolve with abstinence.
Psychological	The ordinary state of	The natural access architecture

dependence on the altered state	consciousness feeling insufficient after repeated profound experiences. The sober world feeling narrow, grey, or meaningless compared to what psilocybin opened. Not physical craving — existential restlessness.	from Section 6 of the LSD guide. Contemplative practice as the sustained path to the territory psilocybin was providing brief access to.
Psychosis precipitation	In susceptible individuals (personal or family history of psychotic disorders), psilocybin can trigger psychotic episodes that persist after the drug clears.	Psychiatric management is primary. The absolute contraindication for psilocybin in psychosis-susceptible individuals applies retrospectively — if psychosis was triggered, clinical treatment is the immediate priority.
Microdosing compulsion	The microdosing practice — not associated with the above risks — can develop its own compulsive quality: inability to tolerate sober days, identity dependence on 'microdosing self,' escalation from sub-perceptual to perceptual doses. Less severe than the above categories but a genuine recovery challenge.	Section 4.4 addresses microdosing specifically. The recovery is establishing sober days, tolerating the ordinary state without the microdose, and identifying whether the microdose was managing an underlying condition (depression, ADHD) that requires its own treatment.

1.5 — The Cultural and Ceremonial Context

THE CENTURION — The Compendium Calls It 'Active Compound, Not Packaging' — But the Packaging Carries History

Psilocybin mushrooms have been used ceremonially for at least 3,500 years — the Mazatec tradition of southern Mexico, the Aztec teonanácatl ('flesh of the gods'), and extensive archaeological evidence from cultures across Mesoamerica. The curandera María Sabina, who introduced Western researchers to the Mazatec mushroom ceremony in the 1950s, described the mushrooms as a language — 'I communicate with the Principal Ones, the spirit doctors.'

This history matters for recovery in two ways. First, it provides the most sophisticated existing framework for holding difficult psychedelic experiences — the ceremonial container, the healer's presence, the ritual structure, the community holding. Many people who use psilocybin outside this container and encounter difficulties would have been better served by it. Second, it means that psilocybin recovery exists in a cultural conversation that includes not only clinical research and recreational use but indigenous knowledge systems that mainstream addiction medicine has largely not engaged.

The Recovery Kernel holds both: the precision language (psilocin, 5-HT2A agonism, DMN suppression, integration failure) and the acknowledgment that this territory

has been mapped by traditions that predate clinical psychiatry by millennia. Recovery can draw from both.

Section 2 — Your Genomic Blueprint

Psilocybin's pharmacogenomic profile is simpler than LSD's in one important respect: no CYP450 enzymes are significantly involved. Psilocybin is dephosphorylated to psilocin by alkaline phosphatases — a non-genetic metabolic step that does not produce the dramatic individual variation that CYP2D6 produces for DXM or CYP3A4 produces for fentanyl.

Gene	What it controls	Key variant	Psilocybin recovery relevance
HTR2A	5-HT2A serotonin receptor — psilocin's primary target	rs6313, rs6311, rs7997012 — variants affecting receptor expression and sensitivity	The primary pharmacogenomic gene for psilocybin — same as for LSD. High-expression HTR2A variants produce more intense psilocybin experiences at the same dose. This explains why some people find even moderate doses overwhelming while others require higher doses for comparable depth. Higher HTR2A expression also likely increases HPPD risk with frequent use. The 'sensitivity' to psilocybin that some people report is largely HTR2A.
SLC6A4 / 5-HTTLPR	Serotonin transporter — expression level affects the serotonin system environment in which psilocin acts	Short/short (S/S) allele — reduced SERT expression	Unlike MDMA (which floods SERT) or DXM (which inhibits SERT), psilocin does not primarily act on serotonin transporters. However, the serotonergic environment — the baseline serotonin tone determined by SERT expression — affects the context in which 5-HT2A agonism occurs. S/S carriers with lower baseline serotonin may experience psilocybin's serotonergic effects differently — potentially more intense emotional content. Also relevant to the underlying depression or anxiety that may have driven psilocybin use.
COMT	Dopamine and stress chemical clearance; also affects HPA axis reactivity during psilocybin	Val158Met (rs4680)	Met/Met (Sage, slow COMT) — same psychosis-adjacent risk as in the LSD guide. The Sage constitution under psilocybin's profound experiential load, particularly at high doses, faces higher risk of destabilizing experiences. COMT Met/Met in combination with family history of psychotic disorders is the specific vulnerability profile. Recovery for

			Sage COMT: anxiety management is the concurrent primary target, and contemplative practice before the next psilocybin encounter (if considering therapeutic use) is the preparation recommended.
MTHFR	Methylation — serotonin synthesis foundation	C677T (rs1801133), A1298C (rs1801131)	MTHFR variants reduce serotonin synthesis capacity — the very system that psilocybin was flooding. This creates the same deficit-seeking pattern as with MDMA: the person whose baseline serotonin is impaired by MTHFR variants finds in psilocybin's 5-HT2A activation a resolution of a chronic biological insufficiency. 5-MTHF supplementation addresses the baseline deficit and is often transformative for the depression or anxiety that drove psilocybin use.
BDNF Val66Met	Brain-derived neurotrophic factor — psilocybin's neuroplastic mechanism	Val66Met (rs6265) — Met allele reduces BDNF secretion	Psilocybin's therapeutic mechanism includes significant BDNF upregulation — the same neuroplastic opening that produces the 'afterglow' period of cognitive flexibility and the sustained antidepressant effects documented in trials. Met allele carriers have reduced BDNF secretion, potentially experiencing less robust or shorter-lasting neuroplastic effects from psilocybin sessions. Exercise (the primary natural BDNF driver) is particularly important for Met carriers in the integration period after psilocybin — supporting the neuroplastic window that the experience opened.

Phenotyping Without Testing

- Did psilocybin consistently produce more intense experiences than peers at the same dose? → High-expression HTR2A variant. Dose sensitivity is the signal.
- Were the experiences primarily emotionally overwhelming rather than visually overwhelming? → The emotional intensity character of psilocybin is partly a feature rather than an abnormality, but overwhelming emotional content at standard doses may reflect HTR2A sensitivity alongside Sage COMT elevated baseline arousal.
- Did psilocybin seem to specifically address a chronic low mood or emotional flatness that nothing else touched? → MTHFR-variant serotonin deficit is

likely. 5-MTHF is the direct address — often more effective than psilocybin's serotonin flooding for the daily emotional baseline.

- Did you develop HPPD-type visual phenomena? → HTR2A high expression + heavy use. Section 4 of the LSD guide applies directly.
- Did psilocybin seem to have very little effect at doses others found transformative? → Possibly low-expression HTR2A variant, or the serotonin system environment was different. SSRIs significantly reduce psilocybin's effects by downregulating 5-HT2A receptors.

Section 3 — The Recovery Framework

THE CENTURION — Like LSD — But Shorter, Warmer, and With Better Clinical Evidence for What Was Being Sought

Psilocybin recovery is closely parallel to LSD recovery: no physical dependence, no withdrawal, no medical detox. The challenges are psychological — integration failure, HPPD if present, psychological dependence on the opened states, and the meaning reorganization that repeated high-dose psilocybin experiences produce.

The LSD guide's Section 3 ('The Recovery Framework') applies in full. Rather than duplicate it here, this guide notes the psilocybin-specific differences and additions.

3.1 — Psilocybin-Specific Recovery Differences from LSD

Variable	Psilocybin-specific notes	Recovery implication
Shorter experience duration → shorter afterglow window	Psilocybin's 4–6 hour duration means the BDNF-enhanced neuroplastic afterglow window (optimal integration time) is also shorter — peaking in the 24–48 hours post-session rather than the 48–72 hours for LSD.	Journaling and active integration work should begin as soon as possible after the session — ideally in the hours following, while the material is still accessible. The window is shorter than with LSD.
More emotional content → different integration target	Psilocybin experiences more often surface specific personal and relational material — memories, relationships, emotional patterns. The integration work is therefore often more psychotherapy-adjacent and less philosophical/cosmological than LSD integration.	A therapist (ideally psychedelic-informed) is a more central integration resource for psilocybin than for LSD. The specific emotional content that surfaced may be trauma-adjacent and may benefit from EMDR or somatic therapy specifically, not only journaling and contemplative practice.
The therapeutic context is more accessible	Oregon and Colorado now have legal supervised psilocybin therapy. Licensed facilitators in the Netherlands (psilocybin truffles are legal) and retreat centers in Jamaica provide legal options. The therapeutic frame provides a container that can make psilocybin's effects safer and more intentional than recreational use.	The person in psilocybin recovery who has depression, PTSD, OCD, or alcohol use disorder — conditions for which psilocybin therapy has emerging evidence — faces the same therapeutic psilocybin question as the ketamine and MDMA guides: the same compound that was problematic recreationally may be appropriate in a supervised therapeutic context. HPPD and

		psychosis history are contraindications regardless.
Species variability in mushroom potency	Psilocybe cubensis is the most common cultivated species. Psilocybe azurescens, Psilocybe semilanceata, Psilocybe cyanescens are substantially more potent per gram — 2–4x the psilocybin content. Potency also varies by growing conditions, harvest time, and storage. Unlike pharmaceutical psilocybin, mushroom psilocybin content is not standardized.	If integration failure occurred partly because doses were consistently higher than expected — species variability or a switch to a more potent species may explain the severity. Understanding this prevents self-blame for 'not handling it well' when the reality was significantly higher-than-expected doses.

3.2 — The Aftermath Timeline (psilocybin-specific adjustments to the LSD timeline)

- Days 1–3: The afterglow and its management. BDNF is elevated. The integration window is active. Prioritize journaling, therapy, and reflective practices during this period. Avoid high-sensory inputs, demanding social situations, and anything that moves attention away from the integration material.
- Week 1: HPPD assessment if relevant. Sleep monitoring — psilocybin disrupts sleep architecture significantly in the days after high-dose sessions. The sleep protocol from Section 4 applies.
- Weeks 2–8: The integration work is the primary recovery activity. Psychedelic-informed therapy if possible. Community. The HPPD management protocol if persistent visual phenomena.
- Months 1–6: 5-HT2A receptor density recovering. HPPD resolving for most. Contemplative practice deepening. The meaning that psilocybin opened beginning to metabolize into genuine life wisdom.

Section 4 — Biological Reconstruction

Psilocybin recovery biological reconstruction is similar to LSD recovery — no MAT required, no physical dependence to address, the primary focus is supporting the 5-HT2A receptor system recovery, the serotonin synthesis foundation, and the neuroplasticity that psilocybin's BDNF effects opened.

4.1 — The Methylation Foundation

- 5-MTHF (400–1000mcg morning): serotonin synthesis support — the same foundation as MDMA recovery, because the serotonin system that psilocybin was flooding is the same one that methylation supports in synthesis.
- Methylcobalamin (1000–2000mcg sublingual, morning): B12 for methylation cycle completion.
- P5P (25–50mg morning): cofactor for serotonin synthesis enzymes.
- Magnesium glycinate (400–600mg morning and evening): serotonin receptor function support; anxiety reduction during integration period.

4.2 — Serotonin System Support

⚠ WAIT 3–5 DAYS AFTER ANY PSILOCYBIN SESSION BEFORE ADDING 5-HTP — ALLOW THE 5-HT2A RECEPTOR SYSTEM TO COMPLETE ITS NATURAL RECOVERY FROM THE SESSION'S AGONISM BEFORE ADDING SEROTONIN PRECURSOR. THIS IS THE SAME CAUTION AS IN THE MDMA AND DXM GUIDES.

- 5-HTP (50–100mg evening, after Day 3–5): serotonin precursor supporting the 5-HT2A receptor environment recovery. Evening timing for sleep architecture support via melatonin synthesis.
- Inositol (4–8g daily): 5-HT2A receptor sensitivity modulation; anti-anxiety; social anxiety dimension of psilocybin use.
- Omega-3 DHA + EPA (2–4g daily): neuronal membrane support for 5-HT2A receptor environment; anti-neuroinflammatory.
- EGCG (400–800mg morning): same neuroprotective role as in MDMA recovery — antioxidant protection for the serotonin receptor system during recovery from repeated 5-HT2A activation.

4.3 — BDNF Maximization: The Neuroplastic Window

THE CENTURION — Psilocybin Opened the Window. Exercise and Integration Climb Through It.

Psilocybin's BDNF upregulation — documented in both animal models and human neuroimaging studies — creates a period of enhanced neuroplasticity in the days following a session. This is the mechanism of psilocybin's antidepressant effects: new neural pathways can form more readily during this window, and those pathways can represent healthier cognitive and emotional patterns. The compendium's lion's mane and BDNF stack is directly relevant here — supporting the neuroplastic window that psilocybin opened with additional BDNF support.

- Vigorous exercise (daily, 30–45 min): the primary natural BDNF driver — most powerful in the 48 hours after a psilocybin session. The neuroplastic effects are additive.
- Lion's Mane mushroom (500–3000mg daily): the compendium specifically names lion's mane as stimulating NGF and BDNF with 'good clinical evidence.' During psilocybin recovery — particularly in the integration period — lion's mane supports the neuroplastic growth that psilocybin's BDNF activation opened.
- Sleep optimization: BDNF synthesis peaks during deep sleep (N3 slow-wave). The sleep disruption of the post-session period competes with BDNF synthesis. The sleep stack from LSD guide Section 3.2 applies.
- NAC (600mg morning and evening): glutathione support; anti-neuroinflammatory; some BDNF-supporting properties.

4.4 — Microdosing: The Distinct Recovery Challenge

THE CENTURION — Sub-Perceptual Use Can Still Develop Its Own Compulsion Pattern

Microdosing psilocybin (0.05–0.3g, typically 1–3 days per week following various protocols) is a distinct practice that does not produce the acute HPPD, integration, or psychosis risks of higher doses. It has genuine evidence for mood enhancement, creativity, and ADHD-adjacent benefits. It is also not without its own recovery challenges.

Microdosing recovery challenge	What it is	Recovery response
Intolerance of sober days	The inability to tolerate off-days — ordinary consciousness feeling insufficient, flat, or unpleasant without the microdose. The sober state becomes aversive through contrast with the microdose	Planned sober periods extending gradually. 5-MTHF and exercise as the biological sober-state support. Treat the intolerance of the ordinary state as the primary recovery target — the microdose is symptomatic

	state.	of a baseline that needs support through other means.
Dose escalation	The microdose gradually escalating from sub-perceptual toward perceptual as tolerance requires higher doses for the same mood effect.	If doses have escalated to where effects are consistently perceptual, this is no longer microdosing — it is low-dose recreational use with a different name. The full psilocybin recovery framework applies.
Masked underlying condition	Microdosing effectively managing depression, ADHD, or anxiety without the underlying condition being properly diagnosed and treated — leaving the person dependent on the microdose for daily function.	Underlying condition assessment and treatment is the priority. MTHFR variant → 5-MTHF. ADHD → appropriate non-stimulant treatment. Depression → psychiatric evaluation. These interventions address the condition the microdose was managing.

Section 5 — The Integration Work

THE CENTURION — Psilocybin Speaks in Emotion. Integration Is Learning to Hear It.

The LSD guide's Section 5 covers integration comprehensively — journaling during the afterglow window, psychedelic-informed therapy, community with others doing similar work, contemplative practice, somatic work, creative expression, and the long arc of the meaning crisis. All of it applies to psilocybin.

The psilocybin-specific addition: because psilocybin experiences tend to surface more emotionally specific and relationally concrete material than LSD — specific people, specific memories, specific emotional patterns — the integration work for psilocybin often has a more psychotherapy-specific character. Where LSD integration might involve philosophical and cosmological meaning-making, psilocybin integration often involves more personal grief work, relational healing, and the processing of specific emotional content that the experience surfaced.

5.1 — The Psilocybin-Specific Integration Toolkit

- Immediate post-session journaling: within 2–4 hours of session resolution, before sleep. Not interpretation — description first. The specific images, feelings, and emotional content that arose. The journaling in this window captures material that will fade rapidly.
- Body-based integration: somatic experiencing, yoga, dance, or any embodied practice that processes the physical-emotional residue. Psilocybin experiences leave somatic traces — the body holds what the mind has not yet metabolized. Body-based integration is more specifically important for psilocybin than for LSD.
- Psychedelic-informed therapist: a therapist who understands psilocybin phenomenology specifically — its emotional surfacing quality, its relational content, its connection to grief and trauma — is a more targeted resource than a general therapist.
- Community integration circles: groups specifically for psychedelic integration provide both peer understanding and a structure for the meaning-making conversation that individual journaling cannot fully accomplish.
- The Mazatec/indigenous tradition as framework: for those drawn to the cultural context, the indigenous ceremonial traditions that have held psilocybin experiences for millennia provide both practical container frameworks (the role of the healer, the ceremonial context, the communal structure) and philosophical frameworks for the cosmological dimensions that psilocybin experiences often include.

5.2 — The Emotional Content Protocol

When psilocybin surfaces specific emotional material — grief, relational wounds, family patterns, trauma memories — that material is not resolved by the session. The session surfaces it. Integration is the resolution.

1. Name the emotional content specifically: not 'I felt sad' but 'I saw my relationship with my father as a pattern of seeking approval I never received, and I grieved it.' The specificity converts the experience from raw sensation to addressable meaning.
2. Identify the corresponding real-world relationship or pattern: psilocybin's emotional content almost always points at something real — a relationship, a belief, a pattern of behavior. The integration task is identifying what it points at.
3. Act on what the experience indicated: if the experience surfaced a need to reconnect with a family member, reconnect. If it surfaced grief about a loss, grieve it with support. If it surfaced a creative calling that has been ignored, begin. The experience is not complete until it has changed something in the life.
4. Bring the material to therapy: the specific content is therapy material. A skilled therapist can help metabolize what the experience surfaced in ways that journaling alone cannot accomplish.

Section 6 — Building Natural Access to What Psilocybin Provided

THE CENTURION — The Mystical Experience Is Replicable — Through the Roads That the Traditions Built

The research finding that the mystical experience predicts therapeutic outcomes is not merely a clinical curiosity — it is a map. It names the destination: oceanic boundlessness, noetic quality, sacredness, deeply felt positive mood, transcendence of time and space. And every major contemplative tradition has built roads to this destination that do not require pharmacological assistance.

The same natural access architecture from the LSD guide applies here — meditation for DMN suppression and ego dissolution, awe in nature for the vast significance, creative flow for the pattern recognition, contemplative tradition for the sustained path. The psilocybin-specific addition is the emotional and relational dimension: psilocybin's particular gift is the opening of emotional contact — with one's own feelings, with other people, with the grief and love that ordinary self-consciousness protects against. Building this access through non-chemical means requires practices that specifically support emotional openness.

What psilocybin provided	Natural mechanism	Practice	Psilocybin-specific notes
Oceanic boundlessness — ego dissolution, unity experience	Deep meditation (jhana states); sustained holotropic breathwork	Daily meditation practice — minimum 20 minutes. Vipassana or similar systematic practice. Holotropic breathwork periodically with guide.	The ego dissolution of psilocybin — the dissolution of the ordinary self-referential boundaries — is accessible through sustained meditation practice. The jhana states (absorption states in Buddhist practice) specifically produce the oceanic quality documented in the Mystical Experience Questionnaire. Psilocybin provides rapid, ungated access to this state. Meditation builds the path on foot.
Emotional contact — openness to grief, love, beauty	Safe vulnerability with trusted people; therapeutic relationships; genuine community	Scheduled vulnerability practice: deliberate authentic disclosure in safe relationships. Therapy. Community that holds emotional truth. Grief rituals.	Psilocybin's specific gift is the removal of the ordinary defensive emotional structure — allowing grief to be fully felt, love to be fully expressed, beauty to land fully. Building this capacity without psilocybin requires practicing vulnerability in contexts where it is safe to do so. This is the most specific and

			most personally demanding natural porting task for psilocybin recovery.
Noetic quality — the felt sense of genuine insight	Deep contemplative inquiry; philosophical community; writing as thinking	Sustained reading of depth (not content consumption). Philosophical and theological community. Writing as a practice of genuine inquiry rather than expression.	The noetic quality of the mystical experience — the sense that the experience conveyed real knowledge — is accessible through sustained contemplative inquiry. The questions that psilocybin opened are genuine questions. They belong in the philosophical and theological traditions that have been asking them for millennia. These traditions have tools for holding the questions that psilocybin encounters may have not yet provided.
Enhanced sensory beauty — music, nature, art	Deliberate aesthetic engagement; active listening; immersive nature	Active music listening (not background). Extended time in nature. Repeated engagement with high-quality visual art. Concert attendance. The practices of genuine aesthetic encounter.	Psilocybin dramatically enhances the perception of beauty — music sounds more profound, nature more vivid, art more resonant. This enhancement is partly the DMN suppression (allowing sensory information to reach consciousness more fully without the ordinary filtering) and partly the serotonin receptor activation's effects on sensory cortex. Sober beauty access requires the deliberate removal of the ordinary filtering through attentive practice.

Section 7 — The Therapeutic Psilocybin Question

THE CENTURION — The Same Molecule, A Different Container, A Different Question

Psilocybin-assisted therapy is the most clinically advanced therapeutic psychedelic framework as of 2026. Oregon Measure 109 created a regulated facilitator-licensed therapeutic psilocybin service framework. Colorado's Proposition 122 expanded access further. Retreat centers in Jamaica (legal) and the Netherlands (psilocybin truffles legal) provide additional access. MAPS-adjacent therapeutic protocols are available in clinical trial contexts.

The person with a psilocybin use disorder history — and with depression, PTSD, OCD, or alcohol use disorder for which psilocybin therapy has evidence — faces the most nuanced question in this guide series: can the molecule that was problematic recreationally be appropriate in therapeutic context?

Considerations supporting therapeutic psilocybin access	Considerations requiring caution
Psilocybin therapy operates at infrequent intervals (1–3 sessions over a treatment course) in supervised settings — different from the repeated, uncontained use that produced the use disorder. The reactivation risk of use disorder patterns is lower than with more frequent exposures.	HPPD contraindication: existing HPPD is an absolute contraindication. Further 5-HT2A stimulation will worsen the condition regardless of therapeutic framing.
The therapeutic evidence for the conditions that drove the psilocybin use is strong. A person who used psilocybin to manage severe depression — and whose psilocybin use became problematic because they were trying to solve an inadequately treated condition — may be the ideal candidate for supervised psilocybin therapy with proper preparation and integration support.	Psychosis history: if psilocybin has previously precipitated psychotic features, therapeutic psilocybin is contraindicated. The clinical benefit cannot outweigh the documented individual vulnerability.
The integration infrastructure available in therapeutic contexts (trained facilitator, preparation sessions, integration sessions) substantially reduces the integration failure risk that characterized problematic recreational use.	COMT Met/Met + psychosis family history: the highest-risk constitutional profile. Comprehensive risk assessment required before any therapeutic psilocybin consideration.
Full disclosure of the use disorder history to the therapeutic team is both ethically required and clinically essential — it changes the preparation, the monitoring, and the integration plan.	The use disorder patterns: the person whose problematic psilocybin use involved compulsive seeking, escalating doses, and integration avoidance may find these patterns activated by therapeutic sessions.

	Explicit monitoring for these patterns is part of the therapeutic contract.

The Recovery Kernel's position: therapeutic psilocybin in the context of psilocybin use disorder history is a clinical decision requiring collaboration between an addiction medicine specialist, the therapeutic psilocybin facilitator, and a psychiatrist familiar with both psychedelic medicine and addiction. Full disclosure. HPPD and psychosis clearance. An integration plan that specifically addresses the use disorder patterns. This is not a categorical exclusion — it is a categorical requirement for specificity.

Section 8 — Navigating the Recovery Kernel: Your Protocol Map

Phase	Primary tools	Focus	Psilocybin-specific notes
Cessation and stabilization (Weeks 1–4)	Section 4 of this guide; sleep protocol; LSD guide Section 3	5-MTHF, magnesium, DHA, lion's mane; sleep; cannabis cessation; HPPD monitoring	Cannabis cessation simultaneously — the primary HPPD exacerbant. Sleep protocol immediately. 5-MTHF from Day 1. 5-HTP begins Day 3–5. The biological foundation is simpler than most guides in this series because there is no physical dependence to manage.
Integration Sprint (Weeks 1–8)	Journaling; psychedelic-informed therapist; community; somatic work	Processing accumulated experiences; resolving the integration backlog; emotional content addressed in therapy	This is the most psilocybin-specific recovery phase. The integration backlog — the psychological material from multiple sessions that has not been metabolized — is the primary recovery target. A psychedelic-informed therapist is the most important single resource in this window.
HPPD Management (if present, Weeks 1–12)	LSD guide Section 4; physician if severe	Cannabis cessation; antioxidant stack; anxiety management; clonazepam or lamotrigine if clinically indicated	Most psilocybin-associated HPPD resolves within weeks to months of cessation and cannabis cessation. The LSD guide's HPPD section applies without modification.
Underlying Condition Treatment (Weeks 2–12)	Psychiatry; 5-MTHF first; therapy	Depression, anxiety, PTSD — the conditions psilocybin was managing — receive appropriate clinical treatment	5-MTHF before SSRI consideration for MTHFR variant carriers. The therapeutic psilocybin option may be appropriate for some conditions in this population — Section 7 framework.
Natural Access Architecture (Months 1–12)	Daily meditation; vigorous exercise; BDNF stack; contemplative tradition; emotional vulnerability practice	Building sustained non-chemical access to what psilocybin provided	The natural access architecture for psilocybin recovery has a specific emotional dimension — practices that build the capacity for emotional openness, genuine contact with grief and beauty, and the vulnerability that psilocybin was pharmacologically enabling. This is the most personally demanding aspect and the one that most fully provides what psilocybin was

			pointing toward.
Contemplative Long Game (Year 1+)	Contemplative tradition; community; creative practice; service	The destination psilocybin was sampling, built through sustained practice	The person at one year of integrated psilocybin recovery who has a daily meditation practice, a contemplative community, a creative practice, and the hard-won capacity for emotional openness without chemical assistance has built what psilocybin was borrowing. The mystical experience that predicted therapeutic outcomes in clinical trials is becoming accessible through earned means.

A Final Word

THE CENTURION — The Mushroom Was Showing You Something. Recovery Is Learning to See It Without Help.

The compendium's precision is exact and honest: 'Shrooms, Magic Mushrooms → Psilocybin. Active compound, not the packaging.' The packaging — the ceremony, the chocolate, the spore print, the tradition, the friend's backpack — is the delivery system. Psilocybin is the compound. And psilocybin does something specific: it temporarily suppresses the prefrontal apparatus that generates the ordinary self, activates the serotonin receptor system beyond its natural parameters, and produces in the space that opens a specific quality of experience that the research has operationalized as the mystical experience — oceanic boundlessness, noetic quality, sacredness, the felt sense that something real was encountered.

The question that recovery must answer is not whether what was encountered was real. Something was encountered. The experience was real. What remains to be answered is what it was pointing toward — and whether direct, sustained access to that territory is possible through means the nervous system actually owns.

The contemplative traditions have been answering yes for millennia. The meditator who reaches jhana, the Sufi who achieves hal, the Christian mystic in the apophatic encounter, the Zen practitioner in the moment of kensho — all are in territory that psilocybin was providing rapid, ungated, unsupported access to. The access was real. The territory was real. What was absent was the preparation, the container, the community, and the integration — the infrastructure that makes the territory navigable rather than merely visited.

Recovery is building that infrastructure. Daily practice. Contemplative community. The specific practices that build emotional openness — the vulnerability, the grief, the full encounter with beauty — that psilocybin was pharmacologically enabling. The BDNF that exercise drives to support the neuroplastic window. The 5-MTHF that addresses the serotonin synthesis deficit the experiences were temporarily flooding past.

The mushroom was showing you something. The something is real. Recovery is learning to see it without help — slowly, through practice, through earned access, through a nervous system that is gradually becoming capable of what the psilocybin was briefly demonstrating was possible.

What was briefly possible is permanently available. It always was. The practice builds the road.

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Refer to the Recovery Kernel Complete Centurion Compendium and the LSD Guide for all referenced protocols.

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